



Position Paper

Working in a Culturally and Linguistically Diverse Society

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Position Statement

Speech Pathology services in Australia should be responsive to our constantly evolving culturally and linguistically diverse society to ensure equitable access to appropriate information and services.

Development of cross-cultural competence by speech pathologists is essential to facilitate culturally and linguistically suitable service provision.

Effective practice with clients from culturally and linguistically diverse backgrounds will take considerably more time and resources than with clients whose culture and language the speech pathologist shares.

It is recommended that all speech pathology service providers have written policy on how services will meet the needs of clients from culturally and linguistically diverse backgrounds.

Speech Pathologists should develop culturally and linguistically appropriate resources to support effective speech pathology practice. These resources should be shared between jurisdictions.

Education in the area of cultural and linguistic diversity should begin at the undergraduate level and continue to be embedded within the professional development of the lifelong learner.

Speech Pathology Australia recognises the need for research in the area of specific speech pathology practices in culturally and linguistically diverse populations.

Origin and Purpose of the Position Paper

The Speech Pathology Australia *Working in a Multilingual and Culturally Diverse Society* position paper was first published in 2001 to provide information to speech pathologists and speech pathology service providers in developing policy and best practice guidelines with regards to working with clients from culturally and linguistically diverse backgrounds. The 2009 version of the position paper aims to outline trends in Australia's population and reflect recent literature in the area of speech pathology and our culturally and linguistically diverse society.

Background

Definition of Terms

Cultural and linguistic diversity recognises the wide range of cultural groups that are contained within a population group. The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language (Australian Government, 2006).

Cultural Competence is "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations" (Australian Government, 2006, p 7). Culturally competent systems value diversity, are able to assess the culture of the system, are aware of the effects of interaction between cultures, institutionalise cultural knowledge and adapt service delivery to reflect cultural difference (Australian Government, 2006).

Culture is "... the shared, accumulated, and integrated set of learned beliefs, habits, attitudes and behaviours of a group or people or community... at once the context in which language is developed and used and the primary vehicle by which it is transmitted." (Kohnert, 2008, p. 28). It is used here to refer to groups from different language and ethnic backgrounds, including Indigenous Australians and members of the deaf community for whom Australian Sign Language is the first language.

Australian population trends

Australia is one of the most culturally diverse countries in the world (Australian Government, 2006). In July 2009 Australia's total population was just over 21.8 million people (Australian Bureau of Statistics, 2009a). The 2006 census revealed that one in every four Australians (24%) was born in a country other than Australia and 44% of Australians were either born overseas or had at least one overseas-born parent. Australia's population was made up of people from over 200 countries (Australian Bureau of Statistics, 2009b).

The overseas born population in Australia is steadily increasing in number as well as diversity. In regional terms, the highest numbers of overseas born people were from Europe (2.3 million people). Observable trends include:

- Migration numbers in groups whose country of birth is New Zealand, China or India are steadily increasing.
 - Migration numbers in groups whose country of birth is Sub-Saharan Africa have increased rapidly between 1996 and 2005, growing by an average of 6% per year
 - Migration numbers in groups with a European country of birth are declining.
- (Australian Bureau of Statistics, 2009b).

Australia's official language is English, however there are over 200 languages spoken nationally. Trends in languages spoken in Australia reflect both migration patterns and language retention practices in individual language groups. The most commonly spoken non-English language in 2006 was Italian (1.8% of the Australian population), followed by Greek (1.4%), Cantonese (1.3%), Arabic (1.3%) and Mandarin (1.2%). Fifty thousand people in Australia reported that they speak an Indigenous language at home. Overall, 83% of all Australians spoke only English at home and only 1% of the total population spoke no English at all (Australian Bureau of Statistics, 2009b).

The foundations of working in a culturally and linguistically diverse society

The principles underpinning the provision of appropriate speech pathology services to people from culturally and linguistically diverse backgrounds can be found in Federal Legislation (Racial Discrimination Act 1975; Human Rights Equal Opportunity Commission Act 1986), workplace policy and Speech Pathology Australia core documents (Code of Ethics, 2001; Competency-Based Occupational Standards for Speech Pathologists, 2001).

The Racial Discrimination Act of 1975 aims to promote equality amongst all Australians regardless of their cultural background. It also regards as unlawful any form of discrimination against people based on their race, colour, descent, or national or ethnic origin, as set down in a range of Acts (Office of Legislative Drafting and Publishing, 1986).

Speech Pathology Australia core documents encompass a requirement to provide appropriate services to all clients. The requirement to provide culturally appropriate services to clients from linguistically and culturally diverse backgrounds is explicit in the Code of Ethics which states "...we do not unfairly discriminate on the basis of race, religion, gender, sexual preference, marital status, age, disability, beliefs, contribution to society or socioeconomic status" (Speech Pathology Australia, 2000). The Code of Ethics requirements to work towards the best possible service for our clients, to provide accurate up to date information regarding communication, eating and drinking disorders, and the assistance which the speech pathology profession can provide apply equally to those from linguistically and culturally diverse backgrounds.

The Competency-Based Occupational Standards for Speech Pathologists (Speech Pathology Australia, 2001) specifically outline competencies in areas including assessment, intervention and service delivery. Each competency is underpinned by general practice principles which state that the speech pathologist must consider the cultural and linguistic background of the client in all work practices and decision-making.

Recommendations and Guidelines

General Principles

Culture has been reported to be an important factor in the development of one's sense of identity. It has been suggested that cultures may be differentiated by nine basic parameters: views on individual versus group importance; outlook on time and space; the roles of men and women; class and status systems; core values; language; rituals; work ethic; and beliefs about health (Tomoeda & Bayles, 2002). It is essential that speech pathologists reflect on these areas when working in Australian society. To improve cultural competence and sensitivity to diversity, speech pathologists should recognise and reflect on their own culture and be aware of how this may impact on their professional relationships. When working with individual clients from a cultural background different to their own, speech pathologists should spend time developing an understanding of the individual's culture, encompassing as many of the above parameters as possible. As Mokuau and Tauilli'ili (1998) remind us, "the usefulness of...culture-specific information is contingent on the interventionist emphasising an understanding of the uniqueness of the individual in the context of these cultural values" (p. 417).

Bilingualism

Bilingualism should be viewed positively. The ability to communicate in more than one language is an advantage and not the cause or exacerbating feature of any disability (Roseberry-McKibbin, 2002; De Houwer, 1998; Watson, 1999). De Houwer (1998) points out the emotional dimension involved in the use of any language. A child develops their first relationships in the language of the home. An adult will have many memories of their homeland and earlier times attached to the home language. Giving up the home language in favour of using only Australian English has a social and emotional cost, and has not been shown to benefit language learning. Bilingual children with specific language impairment have been found to have language skills in each language which are comparable to the language skills of monolingual children with SLI (Paradis, Crago, Genesee & Rice 2003). Intervention for children in the home language has positive effects on the development of their second language (Duncan, 1989; Kohnert, 2008).

Service Delivery

The style of service delivery will vary depending on the nature of the population served and the policy of the employing agency. While the principles of assessment and management of communication and swallowing disorders remain the same for all speech pathology clients, their application may need to be adapted according to the needs of individual clients. Effective practice with clients from culturally and linguistically diverse backgrounds may take considerably more time and resources than with clients whose culture and language the speech pathologist shares (Lynch & Hanson, 1998; Isaac, 2002).

Depending on the experiences of the community and family, it may be useful to spend time explaining and promoting the service as a precursor to actual service delivery. Lynch (1998) recommended using structures that are an existing part of the target community by, for example, sharing information with community leaders rather than just distributing translated brochures.

Speech pathologists should be prepared to be innovative and flexible. Service delivery models should be developed and reviewed in collaboration with the client's community and other informants.

Alternative service delivery ideas for consideration include:

- intervention services in a naturalistic situation – for instance, daily routines, preparing a meal, participating in a playgroup
- parent training approaches (Kohnert et al., 2005)
- health promotion approaches
- community development
- skilling and learning from co-workers ('two-way training')
- transdisciplinary work

The role of the bi-lingual co-worker

Co-workers may be able to provide the speech pathologist with insight about the typical expectations of community members, and to suggest culturally appropriate strategies that may be more likely to be implemented by the client and family. Bilingual co-workers should be valued for their linguistic and cultural knowledge. It should be ensured that bilingual workers do not work beyond their professional boundaries and qualified assistants, interpreters and translators are engaged when appropriate.

If available, bilingual or bicultural speech pathology assistants should implement programs. Such an approach can be effective and more acceptable to clients and families from culturally and linguistically diverse communities (Duncan, 1989; Miller, 1984).

The role of trained English as a Second Language (ESL) staff

If there is no communication difficulty in the home language, speech pathology services may not be required. Issues arising from the acquisition of English as an additional language may be managed efficiently by ESL support services. ESL teachers have expertise to offer in the area of second language acquisition whilst speech pathologists have expertise in first language acquisition and disorders of language. Cooperative work practices should be pursued. If the distinction between a communication disorder and an ESL issue is not clear, a period of trial therapy could be considered.

The role of relatives and significant others

The role of relatives should be negotiated. Consideration should be given to the cultural expectations of the people involved. In reference to translations of written material and face-to-face interpreting, relatives and friends should generally not be utilised. This is particularly important when discussing significant medical, educational or vocational information.

In most circumstances, asking family or friends to take on the role of interpreter should be a last resort. It is inappropriate to expect untrained individuals to have the linguistic knowledge required or to be able to participate in a professional, impartial manner. Professional, accredited interpreters and translators must be engaged for critical decision-making. However, it is recognised that professional interpreting services are not available in all places for all languages, and alternative arrangements will then need to be considered.

The role of interpreters and translators

Interpreters work with the spoken word. They render information and ideas from one language to another, either simultaneously (as each person speaks) or sequentially (after each person has finished speaking). Interpreters specifically trained to work in health related areas with health professionals, and if possible speech pathologists, should be used. At times, especially with the language groups represented by a small community, working with a telephone interpreter may be the best option.

The interpreter is a colleague, but is not responsible for the running of the speech pathology session. Extra planning will be needed when using an interpreter. Prior to the session, there should be clarification of any important concepts, discussion surrounding the objectives of the session and any specific speech or language observations required of the interpreter. At all times during the session, the interpreter should remain objective, only interpreting what is said by the clinician or the client. The clinician should be aware of the demands on the interpreter, and use techniques (for example chunking of information) which will help to facilitate accurate interpretation. Following the interaction, there should be a dialogue around the relevance of the materials used and any communication patterns that were observed.

Most interpreters belong to the linguistic community of the language they interpret. They may be willing to share insights into that community with the speech pathologist; however, their professional standard of ethics discourages them from doing this (NAATI, 1995). Gentile, Ozolins and Vasilakakos (1996) suggest that the role of an interpreter as a 'cultural bridge' is legitimate provided that information is shared during briefings or continued education but never during the interview or speech pathology session.

Isaac and Hand (1996/97) identified three major purposes for interpretation within a speech pathology context: to collect information during an interview; to assess communicative competence; and to convey information. A positive working relationship should be established, as many interpreters consider working with speech pathologists quite challenging and more complex than other assignments (Clark, 1996/97; Roberts-Smith, Frey & Bessell-Brown, 1990).

Translators are concerned with the written word. They render written text or recorded verbal matter from one language to another, and must ensure that the translation is accurate in word and meaning. Not all interpreters are qualified translators. If translation of material is required, the speech pathologist should be aware of the type and the extent of translation work needed. Lengthy or complicated material may require additional time.

The National Accreditation Authority for Translators and Interpreters (NAATI) is a national standards body owned by the Commonwealth, State and Territory Governments of Australia. NAATI is also an advisory body for the translation and interpreting industry in Australia providing advice and consultancy services on standards, accreditation, role and conduct of translators and interpreters and required skills in various settings (National Accreditation Authority for Translators and Interpreters, 2009).

Specific Considerations

Assessment

The use of standardised English language tests does not provide fair assessment for clients from culturally and linguistically diverse backgrounds (Fagundes, Haynes, Haak, & Moran, 1998).

Decisions regarding assessment procedures should be made with an awareness of cultural biases which may be present in assessment materials or in the assessment context (ASHA, 2004; Fagundes, Haynes, Haak & Moran, 1998). A variety of assessment techniques including dynamic assessment, narrative assessment, curriculum-based procedures and structured observation may be considered (ASHA, 2004). Differences in language structure and developmental patterns mean that tests translated directly from English will not provide meaningful information regarding language abilities in another language (Bedore & Pena, 2008).

In working with children it is important to distinguish between an underlying language disorder (which can be expected to affect learning in the home language as well as English) and language differences which arise from learning a second language. Determining whether language learning difficulties are evident in each language is the gold standard for identification of language disorder in children from culturally and linguistically diverse backgrounds. Practical considerations may, however, make this difficult.

Assessment may take place in the dominant language, as assessment in the weaker language may suggest language disorder (Gutierrez-Clellan, Simon-Cereijido & Wagner, 2008). Language dominance overlaps with, but is not necessarily equivalent to, language proficiency. It considers the relative importance and use of each language in the speaking contexts relevant to the client. Language dominance may be established using self report procedures (Lim et al., 2008).

Assessment of bilingual clients with acquired language disorders must consider pre-morbid skills and patterns of use in both languages. It is important to assess the communicative contexts in which each language is needed. Assessment in both / all the client's languages is recommended. Translation exercises may provide useful information regarding those with high levels of functioning (Kohnert, 2008).

Intervention

The decision regarding language of intervention is one which must be made in collaboration with the family. Factors to be taken into account include:

- family preferences and attitudes
- the range of linguistic and cultural contexts important to the client
- the client's current / past proficiency in both languages
- levels of English proficiency within the home
- the availability of resources to support intervention in the home language
- the clinician's language skills

(Adapted from Roseberry-McKibbon, 2002; Kohnert, 2008)

In working with children, the attitudes of school professionals may also be considered.

There is no evidence to support the elimination of either language from a child's environment (Thorardottir, Weismer, & Smith, 1997).

For clients with acquired communication disorders, recovery of all languages should be examined to facilitate a functional outcome, and decisions made accordingly. Bilingual clients are able to recover functional language skills in both languages (Kohnert, 2008). Client preferences and language dominance should be taken into account, as should consideration of factors that will best facilitate participation in relevant contexts. It may be essential to provide intervention in more than one language (for example, Australian English and home language) as current research does not clearly indicate the transfer of intervention across languages. Where an aged or confused client requires predominantly a LOTE in social situations, the client may need this language in therapy to facilitate rehabilitation and maximise participation in communicative interaction. Baker (1995) pointed out that language use is context-specific for elderly bilingual Australians. Dementia clients may respond only to home/first language as their condition progresses.

It is recommended that, where requested by the family, the speech pathologist aims to arrange intervention in the language(s) used by the client in his/her daily repertoire, particularly the client's home language.

Case History and Background Information

A speech pathologist should obtain factual health, social and developmental case history information from all clients. Additional information is required from clients from culturally and linguistically diverse backgrounds. This may include:

- patterns of language used by the client and family members
- languages and dialects used at home, work and in the community
- attitudes towards bilingualism and the use of Standard Australian English
- age at which learning of each language began, and the context of learning
- current and past literacy in all languages

Rapport should initially be developed to enable the speech pathologist to obtain reliable information about the attitudes of the client and family to relevant issues. When explaining the assessment process to the family the speech pathologist should be sensitive to their reactions. In certain cultures it may seem unkind or cause "shame" to challenge the client's abilities. When a good working relationship has been established, the speech pathologist may explore relevant concepts such as attitudes towards play, education, disability, healing, remediation, and values placed on communication.

Information about the client's migration and post-migration history can be very relevant. The experience of being a refugee is likely to have long-term sequelae. The ethnicity or culture with which the client and family identify should be discussed carefully.

Language

When targeting the language of someone whose first language is not English consideration should be given to:

- characteristics of the first language
- patterns of development in the first language
- typical patterns of bilingual language development
- current levels of proficiency in each language
- pre-morbid levels of proficiency in each language
- typical language recovery following an acquired language disorder

Articulation and Phonology

When working with the articulation or phonology of a person who speaks a language other than English considerations include:

- phonemic or allophonic variations of the language spoken
- knowledge of articulation disorder in the client's language(s)
- the need to distinguish between an accent, dialect, phonological disorder and articulation impairment

American Speech-Language-Hearing Association (2004)

Intelligibility enhancement may be an appropriate therapeutic goal where accent or the effects of the phonology in the first language make the client's Australian English productions difficult for the listener to understand. The client may report significant difficulties in day-to-day communication, or may be concerned about the effect on vocational opportunities (Huntley Bahr, 1998). In order to make appropriate diagnostic judgments, the speech pathologist needs to know about the phonological system of the client's first language and the usual interference patterns that can be expected when someone from that language background learns English as a second language. Testing should include the phonology of both languages (Swan & Smith, 1987).

Voice / Fluency

When working with the voice or fluency of someone from a cultural or linguistic background other than the clinicians own it is important to have an understanding of the typical norms within that cultural group (American Speech-Language-Hearing Association, 2004).

Stuttering behaviours may vary across languages in bilingual speakers, however there is not evidence that stuttering behaviours in individuals who speak two languages from birth. Bilingualism does not impact on recovery from stuttering (Packman, Onslow & Reilly, 2009).

Swallowing and Feeding

A review of the specific cultural factors associated with eating, drinking and mealtimes should be undertaken when managing dysphagia in someone from a different cultural background. Examples of culturally appropriate foods and fluids that clients can manage safely should be provided.

Culturally and linguistically appropriate verbal and written information should always be provided. Use of plain English information, translated materials and photos or pictures to support understanding is recommended.

Alternative and Augmentative Communication

Many factors need to be taken into account when selecting and implementing an alternative or augmentative communication system for use in families from culturally diverse backgrounds. Communication systems need to be both culturally and linguistically appropriate. Specific challenges may include:

- culturally appropriate training for family members
- developing a visual system which includes both languages, preferably with the home language above the pictograph and Australian English below it
- developing an appropriate signing system for use with the home language
- deciding whether to use speech generating communication devices with synthetic speech or digitised speech.

Service Management

Policy Making

Each speech pathology department should have current knowledge of the diversity of culture in their local area. Information should include specific cultural groups and languages spoken, recent trends in population and community support services available.

Staffing policies should recognise the increased time required when working with a culturally and linguistically diverse population. Policy should also outline the staffing profile that best meets the needs of the population being served. This might include:

- recognition of bilingualism in applicants for speech pathology positions
- development of specialist bilingual positions
- the establishment of specialist positions with support from alternative funding sources
- the establishment of exchange agreements with specialist staff from other agencies
- procedures for employing community co-workers, speech pathology assistants and interpreters

Resources

Strong justification may need to be developed for purchase or development of culturally and linguistically appropriate resources. The supporting argument could include:

- a theoretical and clinical statement which supports the case for equity of access to and participation in speech pathology services for people from culturally and linguistically diverse backgrounds
- demographic information regarding the population group
- the level of commitment of time required to develop new assessment materials and teaching programs
- the need to establish interagency partnerships to share resources

In organising resources to meet the needs of the client group, speech pathologists should consider:

- liaising with workers in this field in other disciplines (e.g. community workers and ethnic health workers)
- identifying therapy resources in countries of origin of clients and their families
- contacting Speech Pathology Australia expert advisors
- contacting support groups such as the Multicultural Interest Group
- linking with initiatives in speech pathology departments in neighbouring areas, other cities or states
- investigating funding possibilities from a range of sources
- evaluating the priorities for staff working in the area, for example, research, gaining developmental language information, staff development

Resources could include items such as lists of local community organisations and specific contact persons, lists of translated information sheets or therapy materials.

Staff Orientation

The Australian Government (2006) reported that there will only be equitable access to health services when cultural competence is addressed at every level of the health system. Services should ensure that cultural competence is addressed.

It is recommended that departmental orientation for new staff member include:

- demography of the service population
- linguistic analysis and cultural background of the main languages in the service population
- introduction to or review of culturally and linguistically appropriate speech pathology practice
- information regarding accessing interpreters and translators
- general cultural awareness – encourage exploration of the speech pathologist's own beliefs and value systems and how they may influence cross-cultural practice

Ongoing opportunities for the development of cultural knowledge should be available to all staff.

Education

Staff

Competency Based Occupational Standards (CBOS) describes the minimum skill, knowledge base and attitudes required for entry-level practice of the profession (Speech Pathology Australia, 2001). The document states that speech pathologists at entry level are not required to demonstrate full competence in areas involving complex clients, including those from a culturally and linguistically diverse background. This demonstrates the importance of support and supervision of graduate level clinicians when working with this complex client group.

The development of knowledge is essential for effective practice with clients from a culturally and linguistically diverse background. The need to devote staff time and training to meet competency based standards should be recognised.

Speech pathologists should ensure they have accurate language, cultural and communication information about clients and families. The information might be obtained through:

- Speech Pathology Australia
- current literature and research
- consultation with colleagues
- training arranged within the organisation
- government bodies or community groups such as the Federation of Ethnic Communities Council of Australia (FECCA), local migrant resource centres, literature production centres and regional language centres
- language classes
- specific cultural community groups
- Multicultural Interest Group, the Applied Linguistics Association of Australia (ALAA) or other inter-professional groups of similar interests

Pickering (1995) encouraged us to grow with the reality of a global world and develop cross-cultural competence. Speech pathologists should expect to continue learning throughout their professional life.

Continuing staff development should include:

- changes in the cultural and linguistic demography of the service population
- linguistic analysis and cultural background of languages that are less frequently spoken in the service population
- consideration of broader multicultural and social justice issues which interact with the speech pathology service, such as appropriate educational curriculum, equity of access to services
- government initiatives or changes in immigration policy
- contribution to the education of interpreters and bilingual assistants with special reference to speech pathology clients

University

CBOS (Speech Pathology Australia, 2001) recommends an awareness and understanding of many inter-cultural practice issues at entry level. Therefore, universities with undergraduate and graduate entry programs for speech pathologists should ensure that the curriculum covers content such as bilingualism, cross-cultural competence and intercultural practice.

It is recommended that bilingual ability be acknowledged, when possible, during the selection process for entry to speech pathology courses. Prospective students may have completed Language Other Than English (LOTE) subjects at year 12 or tertiary level. Alternatively, bilingual ability may have been gained through family or other world experiences.

It is important that bilingual students have a high level of English proficiency in order to meet the requirements for entry to the profession.

Research and Future Directions

Australian speech pathologists would benefit greatly from local research addressing cross-cultural issues. Australia has a world-renowned status as a culturally and linguistically diverse society. A recent report into the cultural competence within the Australian health service revealed that frequently people from culturally and linguistically diverse backgrounds were automatically excluded from research (Australian Government, 2006). This must be changed if we are to accurately examine trends within our diverse society.

Useful Contacts

Adult Multicultural Education Services

www.ames.net.au

Australian Bureau of Statistics

www.abs.gov.au

Australian Government, Department of Immigration and Citizenship

www.immi.gov.au

Applied Linguistics Association of Australia (ALAA)

www.alaa.org.au

Federation of Ethnic Communities Council of Australia (FECCA)

www.fecca.org.au

Migrant Services

www.australia.gov.au/topics/immigration/migrant-services

Multicultural Disability Advocacy Association (MDAA)

www.mdaa.org.au

National Accreditation Authority for Translators and Interpreters (NAATI) Ltd

www.naati.com.au

Speech Pathology Australia

www.speechpathologyaustralia.org.au

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